Exhibit 1

IN THE UNITED STATES DISTRICT COURT

CENTRAL DIVISION

MARTIN CROWSON,

Plaintiff,

vs.

JUDD LAROWE, BRET LYMAN, et al.,

Defendant.

COPY

Case No. 2:15-CV-880-RJS

Judge Tena Campbell

DEPOSITION OF DR. JUDD LAROWE

Taken at the Courtyard Marriott
185 South 1470 East
St. George, Utah

On Wednesday, June 6, 2018
At 9:03 A.M.

Reported by: J. Elizabeth Robison, RPR, CCR

private contractor. I provide medical care for the inmates in coordination with the medical department at Purgatory. So I'm not actually the medical director. I believe that title falls to Jon Worlton.

Q. All right. And is it -- okay. Private contractor. Let's just talk briefly about what the terms of your arrangement with the jail are.

Are you on a flat fee, or do they pay you by hour, or how does it work?

A. It's a flat fee.

Q. Do they pay you monthly for that?

A. They do.

Q. Is that the same regardless of the amount of time you put in working there?

A. Yes, it is.

Q. As a private contractor, do you have access to their record-keeping systems?

A. Only when I'm on site.

Q. No remote access, then?

A. There is not.

Q. Do -- how does the -- how do the employees at the jail communicate with you?

A. Several methods. Either via phone or text or faxes, and they will either fax my office, call

Q. Okay. In 2014, Mr. Borrowman was working at the jail as a nurse when this happened.

Did you have another nurse practitioner or a physician's assistant that helped you at that time?

A. I did. Her name was Amy Benedict.

Q. Does Amy still work for you?

A. She does not.

Q. When did Amy stop working for you?

A. I believe March of last year.

Q. Is she a nurse practitioner --

A. Oh, I'm sorry.

Q. Oh, go ahead.

A. Actually, June of last year.

Q. Is she a nurse practitioner or a physician's assistant?

A. Nurse practitioner.

Q. Do you know where she is now?

A. She is working for the Heart of Dixie, a cardiology group in town.

Q. Do you know if Amy had any involvement with Mr. Crowson's case?

A. None whatsoever.

Q. Outside of the jail's record-keeping system, do you keep any records on inmates?

A. I do not.
Q. Do you keep any log of phone calls that you receive?
A. I do not.
Q. If you receive a fax from someone at the jail, is that kept anywhere?
A. If I receive a fax from the jail, I respond to the fax and send it back to them, so that that would be where the record would stay. I don't keep any independent files.
Q. All right. So you, personally, do not have any files related to Mr. Crowson at all?
A. I do not.
Q. Okay. Do you have any independent memory of these events at all?
A. I do.
Q. What do you remember?
A. The best that I can recall, I remember getting a phone call from Mike Johnson. And what he relayed to me was that a patient was having some difficulties, as far as confusion, and the vital signs were not very revealing. They were pretty reasonable at the time. And I remember -- what I remember independently is that we ordered some blood work, a chest x-ray. I just wanted to get a

better feel for what was going on, because his case was not clear-cut. And we moved him, at that point, into booking for closer observation.

And then I also remember a call from Ryan Borrowman, and at that time, the vital signs had changed. They had gone outside of the normal range. I believe most specifically the pulse rate had risen. And at that point, you know, I elected to have him transported to the emergency room.

Those are my only recollections of the plaintiff. I actually don't recall any interactions prior to that or after that. I'm not even sure I saw him in sick call, so I just don't recall.

Q. Okay. Do you remember, with Mike Johnson, was it one phone call or --

A. I only recall one phone call on that.

Q. Okay. As far as evaluating patients, it's true you rely on nurses there in large part when you're not there; right?

A. I do.

Q. In fact, there's no other way to do it, is there?

A. There is not.

Q. They've got to be your eyes and ears?

A. They are.
Q. Do you perform any training of the nurses there or the staff?
A. I do not.
Q. Do you have any interactions with Jon Worlton about training?
A. I don't recall that I have.
Q. If someone there were to ask you to come provide training to the staff, is that something that you would be able to do?
A. I would.
Q. Have you ever had any communications with Jon Worlton about this particular case?
A. The only communications I've had was that there would be a case.
Q. Did you speak with him at all about his involvement or lack of involvement?
A. I specifically did not.
Q. Okay. How about Ryan Borrowman? Have you spoken with Mr. Borrowman about the case?
A. We have specifically not. In fact, we discussed not discussing the case.
Q. Okay. And the same question with Mike Johnson?
A. We have not discussed the case.

Q. How often do you have contact with Mr. Johnson?

A. Quite often. Whenever he works a shift, I will get phone calls. So I have contact with the nursing staff at Purgatory daily.

Q. All right. I want to go back to that phone call with Mr. Johnson.

You said you ordered blood work?

A. I did.

Q. What were you looking for?

A. Any clues as to what was going on. Anything that would help in the evaluation of the plaintiff.

Q. Okay.

A. So I ordered a CBC, which is a complete blood count. And a comprehensive metabolic panel, and that looks at a variety of items. It can give you an idea about whether or not the patient might be acidotic or septic. It can give you an idea about kidney function, liver function, electrolytes, fasting blood sugar. So it's quite valuable in assessment.

Q. Okay. And when you order -- had that ordered, were you looking for anything specific, or were you -- is it just sort of a, "Hey, this is a

Q. Is there a day of the week that you go out to the jail?

A. Usually Tuesdays, sometimes Thursdays.

Q. Okay. During the time period, from 6-25-2014 to 7-1-2014, do you know what day you went out to the hosp -- or to the prison, if you did go out to the prison?

A. I don't have a clue. I don't remember when Tuesday would have fallen in that year. And in addition, Tuesdays and Thursdays are my current schedule. I've gone Mondays. I've gone Wednesdays. So I'm not even sure on that.

Q. Okay. No record -- do you have a record of when you went to the jail?

A. I do not.

Q. Do you have a memory of seeing Mr. Crowson at all?

A. I don't recall ever seeing Mr. Crowson, either during this time frame or any other time frame.

Q. Okay.

A. I may have. I just have no recollection of it.

Q. When you do see a patient, do you record it in the CorEMR?

A. I do. There is a note for each visit that I perform.

Q. Okay. So if you had seen Mr. Crowson, then your name would appear here, in that third column; is that correct?

A. I have no idea on where it would occur.

Q. Okay.

A. So they have an electronic medical record, and I enter in my visits. Where it would appear or not appear, I don't have a clue.

Q. All right. Have you seen anything in the records, that you've reviewed, that would indicate that you did, personally, see Mr. Crowson?

A. I have seen no records of my personal evaluation of Mr. Crowson.

Q. Okay. On 6-28-14, Mr. Johnson noted that, "The BP," I assume that's blood pressure, "is elevated at this time and reported to MD."

A. I'm sorry. What day?

Q. On 6-28-14, at 2:07 P.M.

A. I don't recall that. So...

Q. Okay.

A. It certainly could have happened. I don't recall.

Q. What's -- in terms of what you would have

withdrawal symptoms from heroin similar to what they are from methamphetamine?

MR. MCGARRY: Object as to form.

A. The withdrawal symptoms to heroin, once again, very nonspecific: Nausea, diaphoresis, tachycardia, tachypnea, elevated blood pressure. And those might last longer than methamphetamine. The half-life for heroin is going to be a little longer.

Q. Okay. And when you say a little bit longer, what's the time period, do you think?

A. I don't know. I couldn't give you a precise opinion on that.

Q. What about alcohol withdrawal symptoms?

A. They can last longer. Usually, the time of onset is within 72 hours of cessation. But especially when you're talking about delirium tremens, that can go on for days and days.

Q. Can it go on for weeks?

A. Not weeks.

Q. Can it start weeks after?

A. No, it cannot.

Q. And by "delirium tremens," what do you mean by that?

A. The DTs, the typical symptoms: Visual

hallucinations, auditory hallucinations, tactile. I won't call them hallucinations. But you can have odd tactile sensations, confusion, agitation. And then pretty much the same symptoms as we've discussed with the others.

Q. Would not knowing what kind of work you had done prior to incarceration be a delirium tremens?

A. That's a pretty --

MR. MCGARRY: Object to form.

A. -- nonspecific --

MR. MCGARRY: Sorry, Judd.

A. Oh.

MR. MCGARRY: Object to form. Go ahead.

A. Okay. That's a pretty nonspecific complaint. So that could be part of that.

Q. Okay. Do you recall receiving any information from Mike Johnson that's not contained in these notes?

A. I don't.

Q. As you reviewed these notes, did you see anything in there that you thought would be specific, as it relates to a delirium tremens?

A. No, I did not. These symptoms are nonspecific. There are a lot of different disease

encephalopathy. Specifically, there is a finding of fetor hepaticus. The breath smells fruity, yeah, oftentimes in these individuals. Sometimes there will be jaundice. They can be quite agitated as well. But once again, those fall under many subheadings. But those are the things you might typically see in that case.

Q. Okay. If you suspect that somebody has metabolic encephalopathy, what's the appropriate course of treatment?

A. The appropriate course of treatment in that case, several things. One, you treat the agitation. Number two, you also would give them either neomycin or lactulose. Those help reduce ammonia levels. Typically, you'd give them thiamine, because anyone with hepatic encephalopathy is usually thiamine deficient. They're also usually deficient in other vitamins, so we typically give them a multi-vitamin. We give them thiamine. You would treat them with lactulose or neomycin. You would treat their agitation as well. You know, those are the main things --

Q. Okay.

A. -- that you would use.

Q. What diagnostic tools do you have

available to you to diagnose metabolic encephalopathy?

A. Once again, the blood work. You can sometimes get a clue. If the acid base balance is out of the norm, that can be reflected in a comprehensive metabolic panel. An arterial blood gas would also tell you some of those items. An ammonia level. Although, an ammonia level needs to be drawn arterially to get the best product. So an arterial draw is something that generally only takes place in the hospital.

Q. Okay. How about an MRI?

A. I would not say that that's useful.

Q. Okay. How soon should a person be treated when they have metabolic encephalopathy?

MR. MCGARRY: Object to form.

A. You would like to treat that person when you first realize that that's what's going on.

Q. Why is that?

A. Quicker recovery.

Q. Okay. Can encephalopathy cause permanent damage?

MR. MCGARRY: Object to the form.

MR. MYLAR: Object. Also --

A. Permanent?

nursing staff and myself are all on board with this -- is: You know, the patient comes first. Whatever we need to do to make sure we protect the patient. So no. If Mike had felt that the patient needed to be transported or thought there was even a question, we would have transported him at that time.

Q. Okay.

A. I'm not going to keep someone in the jail when the appropriate course of action is to have them seen in the emergency room.

Q. Which makes your ability to rely on Mr. Johnson critical; isn't that true?

A. It does. It does.

Q. Outside of the -- I know you don't keep notes of -- or records outside the jail.

Do you have any procedures or protocols for following up on patients, who you know have been having some sort of symptoms, like being dazed and confused?

MR. MCGARRY: Let me just ask for a clarification.

MR. SCHRIEVER: Yeah.

MR. MCGARRY: You mean -- so a patient who is still an inmate, when you say "following up,"

not somebody who's been transferred to the emergency department or been released from the jail, but is sill incarcerated?

MR. SCHRIEVER: Correct, and I can make it more specific.

Q. For example, in this case, Mr. Johnson -- the records indicate that he contacted you on June 28th.

Do you have any kind of tickler system or policies or procedures where on June 29th you would call and say, "Hey, what's going on with Inmate Crowson?"

A. I don't. Mr. Crowson was transported to booking or moved from wherever he was before to the booking area, which is immediately adjacent to medical. And when they are moved to booking, medical will do rounds on them every shift, and I believe the deputies check on them every 30 minutes. And so there's pretty close observation. So that ensures good follow-up. And then if something occurs during their rounds or if they're notified by a deputy, they would give me a call.

Q. Okay. Now, I'm not necessarily familiar with hospital protocol or the way hospitals work.

But you have worked in a hospital; right?

A. Correct.

Q. When you have patients under your care in a hospital, is there a -- is there a time period in which the doctor is going to say, "All right. I need to check up on this patient," or is there -- how did that work?

MR. MCGARRY: Object to form. Incomplete hypothetical.

MR. MYLAR: Join.

A. In a hospitalized patient, you would round on them daily. That's a minimum.

Q. Okay. And that's the doctor is going to round on them daily?

A. Correct.

Q. And then the nurses are there in addition to that; right?

A. Correct.

Q. In the jail system, that's different?

A. It's not a hospital.

Q. Right. But the purpose of putting him in booking was so that he could be under observation; right?

A. Correct.

Q. And so the nurses are there checking on him once per shift at a minimum?

him started on the Librium and allow that to kick in.

Q. What's the time frame you expect them to have a response to that?

A. That can be difficult, especially with alcohol withdrawal. Some people, it takes a lot of benzodiazepine to achieve a response. And then other cases, they'll have a response quite rapidly. So that is -- there is a huge amount of variability.

Q. Okay. And the patients that have the response rapidly, is that within minutes?

A. No. It would probably be within 30 minutes to an hour --

Q. Okay.

A. -- with a rapid-acting medication like Ativan. Possibly longer with Librium.

Q. Okay. Would you expect to take more than a day to have a response?

A. It can. It can, but I would hope there would be some improvement.

Q. How about two days?

A. You know, once again, in some individuals, it takes a lot. But two days, I would hope to have seen a response.

Q. Okay. Now, on the 29th, were you aware that Mr. Crowson had been in booking since the 25th?

A. I think the only time I -- I'm not positive when -- of that time frame. I'm not positive that I knew.

Q. Okay.

A. I -- let me restate that. I didn't know at that time how long he had been in booking.

Q. Okay. And we already talked about earlier, but you did not know that he was up in A block --

A. I did not. The first --

Q. -- before that?

A. I thought he was -- when I thought he was in booking was when I received the call from Mike Johnson.

Q. All right. Down there at the note from 6-29-2014 at 3:36 P.M., it's Mr. Johnson's update on his visit with Mr. Crowson at that time.

Were you provided information about that visit?

A. I don't recall. I don't recall on that.

Q. Okay. How about June 30th?

There's no note there. Do you have any

recollection of being provided information about Mr. Crowson on June 30th?

A. I don't.

Q. And then July 1st, 2014, Ryan Borrowman's note indicates he was sent to the ER for more in-depth evaluation.

Is that something he discussed with you?

A. It is.

Q. You didn't have any objection to doing that; right?

A. Of course not.

Q. And if Mr. Johnson, on June 25th, 2014, would have recommended that, you would have had no objection to that either; correct?

A. They are my eyes and ears.

Q. Are you aware of any standards or criteria for diagnosing alcohol withdrawal symptoms?

A. Yes.

Q. What standards are you aware of?

A. Oh, we look for agitation. Once again, hallucination, verbal and auditory confusion. Usually, you're going to have the tachycardia. So those are kind of the standard things that are looked for.

Q. All right. Anything in these notes or

what you know now, were those reasonable thoughts and information that they might think he's withdrawing, based upon the records?

A. It could have been. You know, that was certainly one of the top options in the differential.

Q. Okay. All right. And if someone just starts to exhibit some symptoms of withdrawal in a jail, that's not the time necessarily to send them right off to the hospital, is it?

A. We deal with withdrawal all the time in the prison setting. And in fact, the emergency room will send these patients to us, you know, when it -- when their symptoms become such -- I'll use alcohol withdrawal as a specific one. Because it's the one we see most commonly, and it's easy to state clearly. But when their symptoms become such that you think they're on the verge of DTs or even if they go into delirium tremens, that can be a life-threatening event. And that's when we send them back.

Otherwise, we deal with a lot of their symptoms at the time with what we have available. And usually, it's a Librium taper. They will have the tachycardia, the nausea, the diaphoresis.

A. No. If there's an -- if there's a thought that we need to transfer them, we always err on the side of transporting.

Q. And Mr. Borrowman did?

A. He did.

Q. Have you spoken with either of them, or do you have any knowledge as to why they viewed this situation so differently?

A. I have not. On review of the records, even in Ryan Borrowman's case, I didn't see the vital signs there. I -- it was more of a gestalt on his part, I think, that the patient was doing poorly. There may have been vital signs recorded; I just didn't see them. But if he's going to tell me the patient needs to go, I'm sending him.

Q. Do you know what the results of the chest x-ray were?

A. They were negative, I believe, in that there was no pathologic process noted.

Q. No signs of infection either; right?

A. No, there was not.

Q. Okay. You talked about -- with Mr. Mylar's questions, you talked about seizures, seizure activity, being a sign of withdrawal; is that correct?

A. It can be, yes.
Q. No indication of seizure activity with Mr. Crowson; right?
A. There was none noted.
Q. Okay. What is the jail policy as to when a patient should be transported to an emergency room?
A. I'm not aware of any set policy. There may be. I'm not aware of one. It, usually, is based on a discussion between the nursing staff and myself.
Q. Okay.
A. Our unwritten policy, you know, is protect the patient, protect our license.
Q. What role did Mr. Crowson's prior drug use play in his encephalopathy?
MR. MCGARRY: Object to form.
A. It could have played a huge role in his hepatic encephalopathy. You're not going to develop hepatic encephalopathy de novo. You have to have injured your liver to the point where it's in a tenuous situation, where one more insult can tip you over the edge where your body is not able -- where your liver is not able to eliminate the ammonia, which is typically what we see go.